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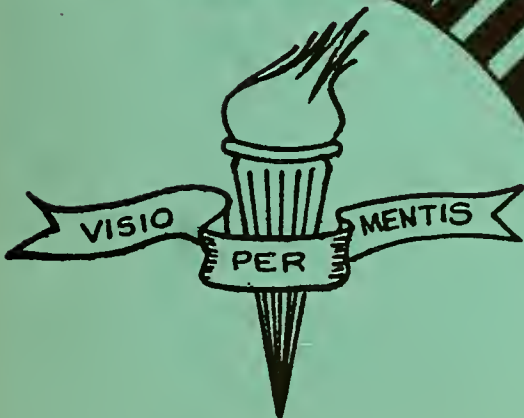
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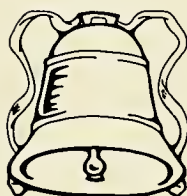
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PUBLISHED BY THE STUDENTS OF THE MASSACHUSETTS COLLEGE OF OPTOMETRY



# THE SCOPE



VOLUME XXV

NUMBER 3

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DIFFERENTIAL DIAGNOSIS BETWEEN PLUS ADD —  
BASE IN PRISM ADD — PLUS AND BASE IN PRISM ADD

	+ Add	B. I. Prism Add	B. I. Prism & + Add
Static Skiametry Subjective Fog	less - static than subj.	more - static than subj.	same
Dynamic Skiametry Induced Phoria (lateral) (P.E.)	lower P.E. than conv. lag	higher P.E. than acc. lag	approx. in ratio
True Adduction (base out to Blur at distance)	low	high	from 8 prism - 12 prism
Adduction } dist. Abduction }	Abd lower in ratio to Add—3:1	Add lower in ratio to Abd—3:1	in ratio
N.R.C. (B.I. Blur) } P.R.C. (B.O. Blur) } near	N.R.C. lower than P.R.C.	P.R.C. lower than N.R.C.	approx. equal
Abduction } Adduction } near	Add higher than Abd	Abd higher than Add	Abd equal to expected Add normal to high
N.R.A. } P.R.A. } near	P.R.A. lower than N.R.A.	N.R.A. lower than P.R.A.	about equal

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# *"The Eyes of the Infant."*

By

RALPH H. GREEN, O.D., D.O.S.

Boston, Mass.

Reprinted from  
The 1939 Year Book  
of  
OPTOMETRY

THIS PAPER has been prepared, primarily, to present the various ocular conditions present at birth, that may be of interest to the practising optometrist. Furthermore, inasmuch as questions, regarding these conditions are constantly being brought up by lay persons, the subject matter is couched in terms comprehensible to those not in the profession. Reference to the following paragraphs, therefore, can be of value to anyone concerned in a not-too-technical treatment of this subject.

## (a). Palpebral Fissure.

In early infancy, the opening formed when the eye lids are separated is practically round. That is, the vertical diameter is nearly equal to the horizontal diameter. This exposes a considerable amount of the eyeball vertically, and gives the appearance of "large eyes" in the infant. The apparent size, however, is due to the fact that, ordinarily, in the adult, only a small portion of the sclera is visible, and the upper lid hangs down on the cornea 2mm., while in the infant, the entire cornea is visible, that is, more of the sclera is exposed. However, as the face develops, the vertical diameter shortens up considerably, and the horizontal diameter increases until, in the adult, a long horizontal oval is formed, measuring, as a rule, 28 x 13 millimeters.

## (b). Lid Movements.

The upper and lower lids are well coordinated at birth. Both upper and lower lids operate together. The normal child never has one eye open and the other closed. In fact, only after considerable training, is it possible to break down this firmly established coordination. The ability to close one eye without the other is an enviable accomplishment even to a six year old youngster.

## (c). Epicanthus.

In the infant, at the inner angle (inner canthus) formed by the joining of the upper and

lower lids, a fold of skin from the upper lid obscures the parts normally visible in this region in the adult. This is commonly seen in the Mongolian, who has a prominent epicanthus, even as an adult. However, in the infant, this fold disappears gradually, as the bridge of the nose develops, exposing the entire inner angle.

## (d). Lachrymal Ducts.

The new-born cries, but without tears. This is due to the fact that the lachrymal gland does not begin to function until several weeks after birth. Frequently, the tear ducts are not fully formed and opened at birth. However, by the time the tears are secreted by the tear glands, the drainage canals should be prepared to conduct the overflow into the lachrymal sac in the nose.

## (e). Sclera.

In the infant, the sclera often has a bluish-white appearance. This is due to the thinness of this lamina, which allows the pigment of the underlying choroid to show through. As the eye develops, the sclera becomes thicker and assumes the usual whitish appearance. If the blueness of the sclera persists, it is generally a sign of some calcium deficiency and is associated with fragility of the bony structures elsewhere in the body.

## (f). Cornea at Birth.

The cornea at birth is no different from that of the adult. If any difference is found, it is usually one in which the cornea has a slightly shorter radius of curvature, resulting in a higher dioptric value than that commonly observed in the adult. A mild flattening process takes place until about the third year. After that, the corneal curves remain constant.

## (g). Corneal Sensitivity.

Sensitivity of the cornea, at birth, is quite reduced and relatively insensitive. This is demonstrated by the failure to elicit the usual lid-closure reflex when the cornea is irritated by a foreign body. For this reason, the eyes do not have the usual protection against foreign bodies that might otherwise have been prevented from coming in contact with the eyeball by the reflex closure of the lids.



(h). Irides.

At birth, the vast majority of babies' eyes have blue irides. However, only a few remain so. Most change to gray, green, and brown. This change takes place as soon as the pigment cells (coloring matter) develop. The more abundant the pigment cells in the stroma of the iris, the greater will be the modification in the original temporary color.

(i). Pupils

The pupils are small, black, and equal in size at birth, and will constrict directly and indirectly when light is thrown into the eyes.

Occasionally, small portions of the pupillary membrane, which generally disappears two months preceding birth, are seen in the newborn. This thin membrane appears to close the pupil either completely or partially. It is then known as, "persistent pupillary membrane".

(j). Crystalline Lens.

The crystalline lens has approximately the same thickness (3.9 mm.) as that of the adult, but the diameter is 6 mm. instead of the 8 to 9 mm. in the adult. Both surfaces present shorter radii of curvature. The anterior measures approximately 4.5 mm. and the posterior 4 mms. making the general shape of the lens spherical. This results in a refracting body that is higher than that of the adult. This in a manner compensates for the short antero-posterior axis (17 mm. in the infant, instead of 24 mm. in the adult) which otherwise would result in a considerable degree of congenital hyperopia. In spite of this natural attempt to compensate for the "short-eye", it falls short by about 3 to 4 diopters, which is the average degree of hyperopia present at birth.

(k). Ciliary Muscle.

At birth, the ciliary muscle, although anatomically completed in growth, is definitely functionally underdeveloped. The tone of the positive-acting fibers of the ciliary muscle is hypotonic, and it is not until the infant begins to acquire vision that functional development begins. Evidence of this development can, as a rule, be seen by the second year. However, this is not to be interpreted that the child does not accommodate before the second year. The fact of the matter is, that the child probably accommodates ahead of convergence, which is before the sixth month.

(l). Retina and Vision.

At birth, all babies are blind for "form vision." That is, they have what is termed "relative

vision." This vision is only the differentiation of light from darkness. The macula is not anatomically completed until the twelfth week after birth, so that, at birth, the eye does not have the completed nervous mechanism required for sharp vision. Aside from the fact that the visual apparatus is not completely developed anatomically at birth, vision must be learned. This is done in much the same manner as other faculties are developed. Vision generally reaches its maximum development about the tenth year.

(m). Convergence.

Since these are the principal muscles of convergence, a short paragraph will be presented relative to their status at birth.)

These muscles are normally relatively hypertonic to the external recti at birth. This accounts for the fact that convergent strabismus is by far the most common type of strabismus in early life. When the binocular coordination is disturbed by the slightest provocation, convergent strabismus results.

With the development of all the extra-ocular muscular coordinations, the tendency is for the tonus to be more equally distributed between the internal and external recti, with their resultant orthophoria.

(n). Ocular Movements.

At birth, and until the child is three months of age, the eyes move more or less independently of each other. However, both eyes can be directed upward and downward in perfect coordination, even at birth. In fact, this is the only coordinate movement at birth.

A new-born will momentarily direct his eyes at a light source. This direction of his eyes toward the light will be imperfect, and either one or the other of the eyes will be directed toward the light source, but never simultaneously. At the end of two or three weeks, most infants can hold steady monocular fixation, but not for any length of time. It is not until the fifth or sixth week that both eyes can be seen directed simultaneously at an object.

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# THE SCOPE

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## THE EDITOR'S MESSAGE—

With a deep feeling of regret, I have informed the President of the Student Council that I will be unable to serve a second term as Editor of The Scope. This decision was not made in haste, but was arrived at early in September, after many months of careful deliberation.

This action is taken in the best interests of The Scope because I simply cannot any longer devote the time and energy which is necessary for the conduct of this important office and I know that the quality of The Scope must suffer should I attempt to continue.

I take this opportunity to publicly express my own appreciation and that of the Student Body to Art Giroux, Associate Editor; Al Lamont, Business Manager; and staff members who have so faithfully discharged their duties in the service of the magazine.

To my successor go my sincere good wishes for a successful regime with a fervent prayer that he may be able to draw upon the Student Body for staff members to give him the strength and support which will enable him to dedicate himself unreservedly to the duties of his office. I trust he shall have a large outpouring of student staff members to help him with his ideas.

Cordially yours,

THOMAS A. COUCH,  
*Editor*

## 280 PARTICIPATE IN WORK OF NATIONAL BOARD EXAMS

Extensive operations of the National Board of Examiners in Optometry were indicated in the annual report of the secretary, Dr. John Uglum, in the meeting of the Board in Seattle in June. In addition to the seven appointed Board members and an office secretary the list of auxiliary professional personnel included 29 *Consultants*, 59 *Proctors*, 6 *Graders*, and 186 *Examination Panel Members*.

The *Consultants* are employed to prepare and submit questions each year for use in the examinations. These questions are assembled and edited by the members of the Board well in advance of the time of examination. The reading of the candidates' papers is done by the appointed Graders, after which their recommendations are reviewed by the Members of the Board.

The candidates are under continuous supervision of a staff of *Proctors* at each examination center. In 1954 Parts I and II of the examinations were given simultaneously in eleven cities, with one candidate taking his examination under military proctorship in Paris, France.

Part III is given individually to each candidate at the office of an *Examination Panel Member*. The 186 optometrists serving on this panel represent almost every state and territory.

In the year 1953-54, 211 candidates took one or more Parts of the examination. The grading is still in process.

Copies of the examination may be obtained from the secretary, Dr. John Uglum, Crow Building, Mitchell, South Dakota as follows: 1952 (Part I only, 25c), 1953 (\$1.00), and 1954 (\$2.00).

A newly published Information Bulletin may be obtained from the secretary on request.

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The difference in actual skill and ability and intelligence between those who succeed and those who fail is usually neither wide nor striking. But if men are nearly equally matched, the man who is enthusiastic will find the scales tipped in his favor. And the man of second-rate ability with enthusiasm will often outstrip one of first-rate ability without enthusiasm. Primarily, enthusiasm means believing in your work and loving it. To an enthusiastic man, his work is always part play, no matter how hard and demanding it is.

—F. E. WILLIAMSON.



*By Buddy Chernoff*

A new field has been opened in optometry. More and more apes in the world today are becoming conscious of the fact that their headaches, and nervousness are due to poor vision. The symptoms are bumping into trees, biting sticks instead of bananas, and mistaking humans for their mates.

The standard 21 point test has to be altered. When taking naked vision, an illiterate "E" chart has to be used. Careful note has to be taken to make sure he hasn't been hanging upside down for any extended period of time. If he has, use a working allowance of two diopters per hour. When doing ophthalmoscopy, instruct the ape to look off into the distance, but if two hairy arms suddenly encircle the examiner's neck, the examiner should rap the head of the ophthalmoscope quickly on the patient's nose thereby allowing the test to proceed. If the patient persists in placing the examiner's head into his mouth, the test should be discontinued and, in place, a six foot static retinoscopy should be then given. From

then on, all near tests should be given just out of arms reach.

During keratometry, place a stick in between the patient's mouth because he has the tendency to bite off the examiner's hand while shifting from primary to secondary meridians. If the patient's head doesn't fit into the keratometer, wrench his head to one side and place it on a pile of books. Focus the instrument from in to out while keeping a torch in his face so that he will not make a sudden grab. Ask him to nictitate freely so that his lacrimal fluid will spread evenly. If the patient does not understand the meaning of the phrase "at two second intervals," smash him with a club on his glabella. To palpate for intra-ocular pressure, take the patient's head in your hands and press the thumbs into the eye and see if the cornea can be made concave. He may become perturbed and rip off your shirt.

The subjective fog is done with the illiterate "E" chart and when V.A. is brought down to 20-40 switch over to a bunch of bananas and ask, "does any banana or group of bananas stand out clearest or darkest?" To make sure the patient doesn't move his head out of the phoropter and thus out

*Please turn to page eight*

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## Fourth Year Article

By Irrelevant

My name is Irrelevant. I'm a big time reporter for a big-time magazine — *Confidential*.

This is my Big Story. A story of woe and bewilderment that shortened my name to Irr. To Irr is human and that I did when I wrote this story. A story that ruined not only the lives of the innocent, but mine as well.

I first became acquainted with this case when I slipped on a poached egg in front of 178 Newberry St., Boston, U.S.A.. There on the curb I met McCarthy at a testimonial in his honor. Together, alone, we gathered the facts, ma'm, the facts about the Faculty.

This is THEIR story. A tale of their secret thoughts and desires, of their hidden past, and of their future to come. *Confidential* now tells you their thoughts through my Big Story . . .

It all began in October, the last Tuesday at eight o'clock.

A man walked in and faced the Embryology Class. What were his hidden thoughts, as he faced the sullen group who sneered at him at periodic intervals. Only *Confidential* knows. They are now told — confidentially — to you.

O. K., Walter, brace up . . . heck, I know my subject, at least I ought to . . . hope they're a friendly class . . . they don't look too aggressive . . . really can't tell . . . some of these kids are throwbacks of humanity . . . some of them must know that this is the first time I've taught this . . . confidence, confidence . . . nothing to it . . . come on now . . . I ought to be at least as good as some of the profs I had . . . Look at them stare . . . what a curious bunch . . . dignified, now, dignified . . . poise, fellow, poise is the thing . . . take it easy and for God's sake don't stutter . . . that's it now . . . I've got control of the situation . . . don't give the wise guys a chance to foul you up . . . just get started and I'll be O.K. . . . last minute look at these notes . . . Mmmmmmm . . . who is that beautiful creature? . . . Oops, wrong textbook . . . all right, all right, take it easy . . . better go slow . . . how's my voice? . . . nice ringing tone . . . a little showmanship . . . just the right touch . . . ha, ha, nice comeback . . . sharp . . . nice allusion . . . now they're warming up . . . who the hell is this little jerk . . . "Catullus said" . . . Sorry, I have small Greek and little Latin . . . ha, ha . . . frankly, I can't see the con-

nection between Catullus and the chick embryo (2 day old) in this reference . . . oh yes, but . . . I think it's somewhat irrelevant, don't you? . . . Well, anyway, let's get on . . . That ought to show him . . . just the right amount of smugness now . . . a little hauteur . . . he looks crestfallen . . . he won't try that again . . . what a dirty look on his face . . . too darned smart . . . twelve minutes to go . . .

Result — O. K., Tyszkowski, you were back against the wall, but you came through with the blue chips. You're a winner and we're behind you.

*Confidential*: When a certain instructor went to school for the first time, the teacher explained to him that if he wanted to go to the washroom at any time he should raise two fingers. He, looking very puzzled, asked, "How's that going to stop it?" Bright boy.

*Confidential*: It happened last year after a final exam. Instructor: Well, what did you think of this course? Student: I thought it was a very all-inclusive course. Everything that was not covered during the year was covered on the final exam.

*Confidential*: You say your instructor talks to himself? So does mine, but he doesn't know it. He thinks someone is listening.

*Confidential*: It happened on Tuesday, the Frosh bumped into an alert, dapper young man (I want to graduate) and snarled, "Say, why don't you watch where you're going?" The man answered, "Listen, do you know who I am? I'm the basketball coach." "Oh, pardon me," said the Frosh. "I thought you were the dean."

*Confidential*: A famous anatomy instructor once said, "Very few women like to sleep on their stomachs, but most men do."

*Confidential*: It happened at the Statler. Have a drink?  
I beg your pardon. I teach at M.C.O.  
Excuse me, here's the bottle.

*Please turn to page eight*

of the myopic fog, nail his ears to either the Maddox rod or the Risley prisms.

The rest of the examination can be done routinely except in the phorias. If a cover test is needed, this is done by shutting the patient's eyelids for him and waiting until he has rested, and then quickly ripping both lids apart and then smashing them shut again.

It has been suggested by various men that a complete history should be taken. If the patient seems reluctant to talk, hang him upside down in a box until he feels like discussing it. Hemholtz claimed that the uninhibited desire to procreate stimulated the complete nervous system thus inducing a pseudo myopia. Tscherning believed that it was the sexual desire, but these depressed the nervous system making him a facultative hyperope. Purkinje claims that these are nothing.

He demonstrated this by sticking a needle into the ciliary muscle, but had his ear bitten off in the process and Purkinje's results have never been tested since. Another claims that the presbyopic add should be given O. U. but this has to be discounted since he thought they stunk, and the har-

mony was poor, giving rise to poor findings. Helmholtz claimed they didn't read enough. The ape said this was silly. Tscherning in a later statement said that Helmholtz was silly.

CONFIDENTIAL . . . (continued)

Confidential: Last year's annual banquet for the class of "55."

Host (Class President): Highball or Martini?

Instructor: Just straight ginger ale, if you don't mind

Host: Pale?

Instructor: No, just a glass.

That's all *Confidential* can confide to you in the space allotted. By now you know that an instructor is a man whose job is to tell students how to solve the problems of life which he himself has tried to avoid by becoming an instructor.

We hope that all instructors who read *Confidential* realize that it was done not to "poke fun" at any particular instructor, but more in a humorous vein to be taken with a grain of salt, which in turn can be greatly improved by dropping it into a glass of beer.



AND NOW, SIR, LIKE IT BETTER ONE OR TWO...?

DIFFERENTIAL DIAGNOSIS BETWEEN  
TRUE AND FALSE MYOPIA

True	False (acc.)	False (conv.)
History of constant blur at distance	History of recent variable blur	History of recent variable blur
Absence of local irritations	local irritations	local irritations
Usually no asthenopia	asthenopia	asthenopia
Large pupils	small pupils	small pupils
Constancy of vision	fluctuations in vision	possible intermittent crossed diplopia at near with fluctuating vision
Constant retinoscopic findings	fluctuations in retinoscopic findings	fluctuations in retinoscopic findings
Considerable play between acc and conv	tight relationship between acc and conv	tight relationship between acc and conv
Acc lags high (dynamic ski and fused cross-cyl.)	Acc lags high (dynamic ski and fused cross-cyl.)	All conv. lags high (comparison of dist. near lateral phorias
High near exophoria (habitual finding)	Eso dist. and possible more eso at near (habit)	Exo. distance with high exo at near (habit)
All blur points high PRC NRC PRA NRA	Blur points NRC low PRA low PRC high NRA high	Blur points NRC high PRA high PRC low NRA low
Ductions (horizontal) dist. and near high	Ductions (horizontal) Abd-dist-low Add-dist-high Abd-near-low Add-near-high	Ductions (horizontal) Abd-dist-high Add-dist-low Abd-near-high Add-near-low



## HYGIENIC MEASURES IN MYOPIA

Between the ages of 8 and 20 myopia tends to appear and to progress. Myopes and those with myopic backgrounds should be advised with regard to the practice of sound eye-hygiene. The following measures should be advised.

1. As little close work as possible. Only the bare necessities should be attempted.
2. All close work should be done under good lighting conditions. (30 F.C.)
3. Posture in reading and close work in general is important. The patient should not permit his head to drop too far forward.
4. Reading in moving vehicles should not be permitted.
5. Outdoor pursuits should be encouraged.
6. Myopes 10 years of age and under with 6 diopters of myopia and over should be advised to attend sight-saving classes, or at least should receive special attention by teachers.
7. Myopes who progress at a rapid rate and resist all optometric approaches should be advised to have a complete physical check-up. Special attention to nutrition should be emphasized.

## FULL MINUS CORRECTIONS FOR MYOPIA

Edward Jackson, M.D., reporting in the "American Journal of Ophthalmology" in the August, 1931, edition, on 77 cases of myopia, each fully corrected to bring about equal results of accommodation and convergence. The average age of the group when first seen was 16. He observed these same cases 9 years later, no attention having been received by these patients in the intervening time.

His results are shown as follows:

No. of Eyes—154.

No Change—44.

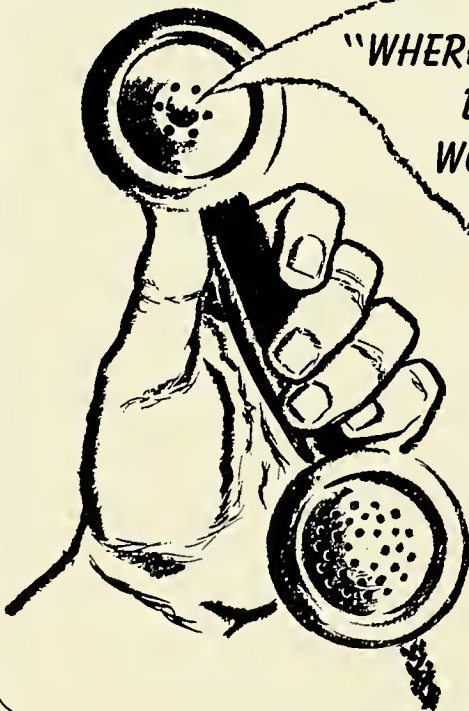
Increase Less than 1.00 D—52.

Increase More than 1.00 D—31.

Decrease—27.

Conclusion: These results cannot be discounted and statistically at least are as good and perhaps better than the results of any other method of healing.

Note: This approach in the management of myopia is the one most ophthalmologists believe to be the answer to adolescent myopia.



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# *Chronic Non-Congestive Glaucoma Diagnosis Chart.*

RALPH H. GREEN, O.D.  
Mass. College of Optometry  
Boston, Mass.

*Age:*—Be suspicious of all patients over 40 years of age.

*Personality:*—Glaucoma is more common in nervous and excitable patients as well as those who live and work under conditions of emotional stress and strain.

*Physical Condition:*—Hypertensive and/or arteriosclerotic patients may be predisposed.

*Subjective Symptoms:*—

a—in early stage completely absent.

b—later stage

colored halos (inner blue-violet, outer yellow-red)

reduced central vision

loss of visual field

frontal headaches

feeling of fullness in the eye on awaking

after staying in a dark room

after wearing deep tinted lenses

after hot bath

after coffee

after emotional upheaval

*Scleral tonometry:*—

a—elevated above 28 mms. of mercury — an early sign

b—provocative tests (to be used in questionable cases)

caffeine

dark room

*Digital tonometry:*—unreliable except in marked departures from normal and marked difference between the two eyes.

*Ophthalmoscopy:*—(fundus)

a—in early stage no departures from normal

b—in later stage

optic disc cupping and pallor

peripapillary halo (yellow-white or yellow-pink)  $1/5$  to  $1/8$  disc diameter in width

arterial pulsation

venous engorgement and tortuosity

arterial constriction

*Cornea:*—

a—Anesthesia, a late change or may be absent

b—haziness, a late change or may be absent

*Light and Color Sense:*—

a—early loss of light sense (low threshold)

b—early loss of color sense (low threshold)

(George Young, M.D., Threshold Test)

*Dark adaptation:*—

a—slow adaptation time, an early sign (Feldman Adaptometer) (decreased sensitivity to dim light precedes loss of light and color sense)

*Pupils:*—

a—in early stage changes insignificant —all reactions appear to be normal

b—in later stage pupils react sluggishly to light and react readily by dilating in darkness

c—last stage pupils immobile and vertically dilated

*Refractive State:*—Glaucoma is more common among hyperopes than among myopes.

*Refraction changes:*—

a—static refraction tends toward myopia

b—dynamic refraction lowered

lowered amplitude of accommodation

requiring higher plus add than expected

requiring more frequent increases in plus add

*Central Vision:*—

a—unimpaired until a late stage and long after the loss of some portion of the visual fields

b—tendency for vision to be lower in early morning

c—impaired central vision a late stage change

*Visual Field changes:*—

a—Seidel's sign, an early change (comet shaped enlargement of the blind-spot above or/and below)

b—loss of nasal quadrant, either upper or lower, leading to formation of Roenne's step, an early sign

c—Bjerrum's sign, a continuation of (a) ending at the horizontal raphe', a later sign.

## THE COUNTRY DOCTOR



They knew him by his gentle voice  
That seemed to ask to share whate'er  
Of grief or woe had chanced to pass.  
And when he smiled, his eyes somehow  
Did gain an entrance to the soul,  
And 'round the cares that spread the day  
A veil of comfort seemed to droop.

He never cared to question why  
Or hesitate if he were called—  
The beating snow, the biting rain,  
The agonizing shriek at dawn  
Were all the same to him—he was  
As one who bears a faith that blinds  
And lifts this clay to immortal spheres.  
His duty was his life—and all  
The countryside adored him.

He never was alone, although  
He used to walk, when all things slept,  
In lonely paths, deserted woods.  
The flowers seemed to open at his step,  
Wild flowers n'er visited by man.  
He never was alone, for always  
Tiny hands were clutching at his neck,  
And a mother's anxious eyes would haunt  
His thoughts—could such a one be lonely?

He knew the truth of all those lives;  
From him no merest hope lay hid;  
And each sweet secret soft reposed  
Within his heart as tho it slept  
And kept its dream upon some height  
With some pale monk who leaves this world  
And seeks a lonely solace with his God.

His hand was first to cool and soothe  
The feverish brow—his hand was last  
To pull the covers tenderly  
O'er some pale face that lately smiled.

And there was not a child for miles  
Around, of whom he could not say  
That he had heard its first, its piteous  
Wail, when now the awful truth had dawned  
That this was life—and soon to die.

In him was virtue consummate.  
He so did lead his life as tho  
He meant that it should be a law,  
A universal light of what was true  
And beautiful. The evening found  
Him by his fireside, wherein  
The curling smoke would weave a faint,  
A magic chain of children's faces—  
And thru the hall the echo fell  
Of pattering feet, and a small child's laugh.

And when he died—he did not seem  
To die at all—he just had left;  
He surely would come back some day  
And bring with him a wealth of joy.  
But n'er did he return;—a mound  
Of green so gently turned, a stone  
On which was writ "Here lies a one  
Whose greatest claim to fame was that  
He did not care for fame"—a sigh,  
As tho a bird had passed—and that was all.

Sometimes I wonder, when the sky  
Does don its fair, its rainbow garb,  
If this be as a magic arch  
Through which the soul of such as he  
Must pass to join the angel crowd.  
For then must all the spheres vibrate  
And fill the void with mighty tone  
To tell the stars that once had lived  
This covenant, between God and Man.

HENRY L. CABITT, M. D.



